Will government responses make it worse?

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OPIOID POLICY FALLOUT

115 people die each day from opioid abuse — CDC

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Physicians are used to fighting for the right treatment for their patients. From requesting prior authorizations to preparing patients for what they will pay at a pharmacy, the physician has to defer to a third party. Now the battle over treatment has a new obstacle: pharmacy restrictions on opioids.

Following on the heels of CVS last year, Walmart announced that this summer, its eponymous stores and Sam’s Club locations will restrict initial acute opioid prescriptions to no more than a seven-day supply, with a cap on potency per day. This policy, like the one from CVS, aligns with the CDC’s guidelines for opioid use.

Walmart says the new policy is a direct action against the nation’s opioid epidemic to curb abuse. The company did not respond to a Medical Economics’ request to discuss the policy.

Many physicians agree there is no single solution to stem opioid abuse and the solution lies in various initiatives from all stakeholders.

But the same cohort would also say that pharmacies setting mandatory limits on opioids with no room for physicians to advocate on behalf of their patients is an overstep. Furthermore, it puts a strain on the already stressed physician-patient relationship when yet another third-party puts up a barrier on the road to wellness.

Add to that the issue of patient access to the opioids some need to quell their pain. Requiring multiple trips to a pharmacy puts up another barrier for those who might have transportation issues as well as the possibility of multiple co-pays per refill.

Here’s something doctors know well: Pain is not the same among patients and technology has yet to design an instrument to truly indicate its severity in the human body.

So setting a stringent limit for all patients and all physicians is not just an overreach, it’s a huge misstep.

I support moves to keep unneeded opioids off the street and safely locked away in a pharmacy. I think being cautious with prescribing is also a good idea—again, not every patient in pain will need the same amount or duration of opioids. And this clearly looks good for Walmart taking such an aggressive stand and being “part of the solution.”

To tell physicians that a pharmacy knows better regarding a patient they have never treated, let alone likely even seen in person, is simply not good policy. The last thing physicians need are additional blanket policies to negate their years of insight and expertise.

Walmart—and its peers—need to be a part of lending a hand to solve the opioid crisis. But not by turning their backs to physicians.

Keith L. Martin is editorial director of Medical Economics. Do you think putting non-negotiable limits on opioid prescriptions is a good idea? Tell us at medec@ubm.com.

“Physicians need to be allowed to exercise their judgement about the appropriate course of therapy.”

“Physicians, not pharmacies, should control opioid prescriptions”

To tell physicians that a pharmacy knows better regarding a patient … is simply not good policy.”
COVER STORY

OPIOID POLICY FALLOUT

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Having health insurance is not the same as access to a physician, writes Ronald E. Cossman, PhD.

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MedicalEconomics.com

Five ways to avoid a phishing attack

A new BakerHostetler study reports that phishing remains the leading cause of data security incidents for the third straight year, and the healthcare industry is the number one target of scammers.

A phishing attack is when someone is tricked by an email message into providing access credentials to an unauthorized party, visiting a phony website, or clicking on a link that installs malware.

The cost is quite high: An average forensic investigation into a phishing attack costs more than $84,000, with the largest investigations costing nearly $437,000. The average time between the incident and discovery is 66 days, with three days from discovery to containment, and then another 36 days to complete the forensic investigation and notification process.

So, how can physicians and their staff protect their practices from being compromised? Eric Packel, a partner at Baker-Hostetler who specializes in privacy, data security, and technology issues, offered five tips, including:

- Determine which employees are most at risk for clicking on a phishing email. "Some companies send out a fake phishing email to test their employees, and those who consistently respond to any phishing emails can get additional education," Packel says. "You can target your training to the employees who need it the most."

- Institute a multifactor authentication process. A multifactor authentication process means that not only do people have to enter in their usernames and passwords, after they click on those, they have to put in an additional code. This code could be sent as a text, to another email address, or it could be a keyfob. "It makes it much more difficult for the attacker to get into the system if you have multifactor authentication," Packel says.

Poll: Do you feel opioid manufacturers were honest with you regarding the addictive properties of their products?

Yes: 32%
No: 68%

Poll conducted on MedicalEconomics.com from February 24 through March 13, 2018

Topic Resource Center

REVENUE CYCLE MANAGEMENT

- How to fix common billing mistakes
- Healthcare billing should look to other industries to improve
- Charge-capture software can increase practice revenue

For more, visit bit.ly/practice-RCM.

Blogger

“With 86 percent of our nation’s healthcare costs being spent caring for patients with chronic diseases, the time for innovative approaches to promoting healthy lifestyles is now and physicians are well-positioned to take the lead in this effort.”

Glen R. Stream, MD, calling for more focus on patient nutrition to improve outcomes
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Drug plan info shouldn’t be a game of hide and seek

While electronic prior authorization can help, they should be combined with easy-to-find drug plans. When I look up a patient’s eligibility with the insurer, the plan should be there. And, when I receive an electronic notification of the prior auth needed, I should have a link to that patient’s drug plan.

Instead, we have to search for it—never sure if we’ve found the right one—and Medicare plans are doubly tricky as the drug plan seems obscure and hard to even name, much less find.

Donna Joiner
CORVALLIS, ORE.

Place a moratorium on prior authorizations now

I read the April 10 article by John Frank, (“Prior authorization bill seeks to address ‘cumbersome’ process) and wanted to reply. Prior authorization and radiology “review” are programs designed by third-party payers to reduce their costs. As physicians, we have allowed this process to accelerate out of control and become progressively burdensome.

Prior authorization is essentially asking the physician to do his work again, to try to save money for the insurance company. This abuse is even more apparent in radiology review programs.

A few egregious examples should serve to demonstrate how abusive the process is.

I recently had a patient on only generic prescriptions for diabetes, lipids, and blood pressure. This patient had survived a stroke two years ago. When her prescriptions were submitted for renewal to [pharmacy benefit manager (PBM)] OptumRX, each prescription was denied. After multiple communications, the patient’s drugs were slightly changed, but she was without medication for several days. Fortunately there were no negative effects.

Another case involved a patient with a history of ulcer disease who had local back pain, which responded to lidocaine patches. When the prescription was submitted for renewal, the PBM denied it because it was not for post-herpetic neuralgia. This drug is also generic, improved patients’ quality of life dramatically, and certainly is safer than narcotics, muscle relaxants, and NSAIDs in a patient with ulcers.

A final example of moronic approach to prior authorization is manifest in a patient case of a gentleman on Oxycontin (15 mg), who was sent through the process, and a new prescription for 10 mg required a new prior auth.

I would propose that a moratorium on prior authorization is the answer. Doctors should refuse to participate at all. Consequences of not paying for needed medications should fall to the PBM and insurance companies. PBMs are the worst kind of “middle man.”

Their assistance was not sought by doctors nor patients, but by another “middle man”—payers.

Let us start to redirect the system to patient care and concerns first. Accurate formulary information during real-time prescribing would remove the need for prior authorization.

If Congress feels compelled to “help” limit new and patented drug costs, I would propose a 200 percent “tariff” on any prescription drug advertising. This cost has no benefit to any part of the healthcare system. It also might help balance the federal budget.

Michael Berard, MD
COLLEGE PARK, MD.

Drug plan info shouldn’t be a game of hide and seek

While electronic prior authorization can help, they should be combined with easy-to-find drug plans. When I look up a patient’s eligibility with the insurer, the plan should be there. And, when I receive an electronic notification of the prior auth needed, I should have a link to that patient’s drug plan.

Instead, we have to search for it—never sure if we’ve found the right one—and Medicare plans are doubly tricky as the drug plan seems obscure and hard to even name, much less find.

Donna Joiner
CORVALLIS, ORE.

In response to “Value-based care will add fire to physician burnout”:

So called “value-based care” is a one sided equation and will never work. It does address the biggest obstacle to obtaining quality outcomes, namely the ability of the patient to afford their medications or patient compliance with doctor’s orders.

If you can’t afford the medications, do not take them as instructed, and do not change your diet, exercise regimen or quit smoking, then outcomes reflect only one side of the reimbursement equation. This is simply another way for government and third-party payers to line their coffers on the backs of what was formerly known as the medical “profession,” now known as the “healthcare industry.”

Trey Kirby, DO
MCMINNVILLE, TENN.
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What patients actually want from their doctors

A new report from the Medical Group Management Association and online healthcare information provider Healthgrades examined millions of online reviews of physicians and other healthcare providers to answer an important question: “What do patients think about their interactions with doctors?”

“The quality of staff interactions is important to patients

How staff ranks among top factors in reviews

Negative comments

- Communication: 3.8%
- Time: 12%

Positive comments

- Staff: 23.3%
- Bedside manner: 5%
- Knowledge: 11.7%

“Overwhelmingly, patients highlight non-clinical factors when evaluating care quality, including physician personality, time spent with the physician, and interactions with office staff.”

—Patient Sentiment Report

Patients’ feedback of their doctors is overwhelmingly positive

70% of ratings are 5-stars (the highest rating on Healthgrades)

The average rating is 4-star

Average rating for internists/family practice: 3.9 stars

Only 22% of reviews are 1-star

Patients value the time they spend with clinicians

“Time” is mentioned in 32% of positive reviews and 25% of negative reviews

Patients view healthcare first and foremost as a personal interaction.

Coping with annual wellness visits

Q: Can I bill an established patient preventive medicine exam (CPT 99397) with a Medicare Annual Wellness Visit (AWV)?

A: We don’t usually see a 99397 and an AWV. Medicare discourages this and says there is too much “crossover” between these two preventive services. We usually see a 99213 or 99214 with a G0438 or G0439 to represent the problem management outside the AWV. If you bill G0438/G0439 and a 99397, recognize that Medicare does not cover the 99397. Some Medicare secondary payers will, but you’d better have pretty good knowledge of the patient’s payer type or else you are consigning them to a pretty big bill, as well as for the screening labs that could go with it.

If you bill both of these codes, it would be best to label each section precisely and say what you are doing in the chief complaint (i.e. here for Medicare AWV and Annual Physical Exam/Health Maintenance). Be sure you have all the AWV elements under that heading, and do a decent life-cycle commentary, review of systems, patient family and/or social history, and comprehensive exam. It needs to look like two very distinct things.

Q: We saw a patient today and it appears the vitals we entered were not saved to the system. Is there a way that we are able to document that the vitals are lost and if so, are we still able to bill for the visit?

A: Most E&M visits beyond a 99211 include the “constitutional” or “general” system on exam, but they don’t have to. Primary care physicians document principally under the 1995 documentation guidelines—which are at the organ-system level. So comments such as “ill-appearing” or “well-appearing NAD” count as constitutional—you don’t actually need vitals. It is likely that your docs typically document well-enough that one minor miss like this wouldn’t impact coding. Just to be thorough, and from a risk management perspective, the physician may wish to add an addendum that for some reason vitals were not recorded but that there were no major concerns.

Q: I saw a new patient that was recently discharged from rehab. Can I bill for a Transitional Care Management (TCM) code?

A: The TCM codes are about transitioning back into the community and dealing with problems of at least a moderate level of complexity. They are not limited to a particular provider type, although they were designed with primary care in mind. You do not have to be the “owner” of the patient, or the problems, for you to assess them. Two of the requirements that Medicare outlines are:

- The healthcare professional accepts care of the beneficiary post-discharge from the facility setting without a gap; and
- The healthcare professional takes responsibility for the beneficiary’s care.

If you meet these criteria, as well as the other TCM requirements, you are good to go. Do remember though that only one provider can bill the TCM service per hospitalization.

Coding Insights

Bill Dacey, CPC, MBA, MHA, is principal of the Dacey Group, a consulting firm dedicated to coding, billing, documentation, compliance. Send your coding questions to medec@ubm.com.
The epidemic of opioid-related deaths sweeping the country has lawmakers and regulators in Washington, D.C., and state capitals scrambling for answers. And while doctors generally welcome the attention to the crisis, many also fear that the solutions being proposed and enacted will do more harm than good.

The concern among physicians and public health and pain management experts is that laws and regulations designed to limit use of prescription narcotics, however well-intentioned, are yet another constraint on doctors’ ability to treat patients as they think best.
Worse, they say, some of the limitations on prescribing could result in patients turning to heroin or buying the medications on the street. And because heroin in particular now is often laced with fentanyl and other synthetic painkillers, doing so astronomically increases the risk of death.

**BALANCING NEEDS OF PATIENTSVERSUS THE COMMUNITY**

Still, nearly everyone agrees that the staggering death toll from opioids—now around 115 people each day, according to the CDC—needs to be reduced.

That responsibility often falls to primary care doctors, who write about half of the nation’s opioid prescriptions, according to the CDC. It also leaves them to grapple with the question voiced by Alan Schwartzstein, MD, a primary care physician in Oregon, Wisc.: “How do we provide patients with adequate management of their chronic pain without having medications that could be a danger to themselves or others out in the community?”

While opioid-related deaths have been rising for well over a decade, government efforts to address the crisis only got underway in earnest in 2016. That’s when the CDC issued its comprehensive “Guideline for Prescribing Opioids for Comprehensive Pain,” and President Obama signed into law the “Comprehensive Addiction and Recovery Act of 2016.”

Around the same time, state legislatures began considering—and in some cases adopting—laws aimed at curbing opioid abuse. As of July 2017, 23 states had passed legislation with some type of guidance, limit, or requirement related to opioid prescribing, according to the National Council of State Legislatures.

Most of the state laws limit first-time opioid prescriptions to a set number of days, ranging from three to 14. Many also mandate that doctors consult their state’s Physician Drug Monitoring Program (PDMP) before writing an opioid prescription, to ensure that the patient isn’t getting medications from multiple prescribers.

**OPPOSITION TO NEW CMS RULE**

The most recent action aimed at reducing opioid use occurred in April of this year, when CMS approved a rule denying coverage (with some exceptions) for Medicare Part D beneficiaries whose total daily opioid use exceeded a set number of days. Many physicians address chronic pain with non-pharmaceutical solutions—exercise and physical therapy—and/or non-opioid medications.
**Policy**

## Opioids

“If I do start prescribing opioids, it’s only after a careful discussion about the benefits and risks, either for the patient or others who might potentially access them.”

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**The case for outside intervention**

Anna Lembke, MD, knows that where government regulation of opioid prescribing is concerned, she is an outlier. While most doctors resist any limits on their ability to treat patients as they think best, Lembke thinks that reducing opioid use requires intervention by legislators and other outsiders.

Lembke’s willingness to accept government-imposed limits on opioid prescribing is based on the need to counter what she calls “perverse incentives” in the nation’s healthcare system to overprescribe the medications, as demonstrated by the fact that as of 2015 American physicians were prescribing three times more opioids than in 1999, and nearly four times more than their European counterparts, according to a 2017 JAMA article.

The growing number of physicians leaving private practice to work for hospital systems creates another reason for doctors to overprescribe opioids, says Lembke. “Employed doctors are under enormous pressure to see patients quickly and to get good patient satisfaction scores because those can impact professional advancement,” she says. “Opioids work really well to address those needs, at least in the short-term, so prescribing them is the easy thing to do.”

Still another factor favoring opioid prescribing, Lembke says, is Americans’ attitude towards pain. “In general, I think the cultural trend is toward the belief that any amount of pain is too much,” she says. And while that attitude stems from a variety of causes, the pharmaceutical industry promotes it. “Their attitude is, ‘If you’re experiencing any pain, you have an illness and your doctor has a responsibility to treat that,’” she says.

Given all the incentives in favor of opioid prescribing, Lembke says, “I think there needs to be external controls, because left to their own devices doctors won’t be able to limit their prescribing to the extent necessary to impact this public health crisis.”

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Solutions put burdens on patients and medical practices

Continued on page 44
Connect with patients through video

Video has been growing in popularity for some time. Look at the growth of YouTube, which has over one billion active users and 30 million visitors per day. Video is engaging, and it can say a lot in a short amount of time. Why does this matter in healthcare? The industry is looking for better ways to attract, engage, and interact with patients who are more likely to change providers for a better experience.

Solutionreach’s Patient-Provider Relationship Study showed that one in eight patients left a provider in the past year and a quarter of them indicated they left because of poor experience. They want better communication, better service, and more convenience.

In addition, with 84 percent of patients looking at providers’ online reputations before booking, video is also a great way to introduce patients to your practice. If a practice uses video on their website, they are 53 percent more likely to show up first on Google.

Practices can use video to appeal to patients looking for a new provider, engage existing patients on social media, and educate and entertain patients between visits. To use video successfully however, there are some things to keep in mind:

1. Be concise
   Because people have such a short attention span, videos need to be short and sweet. A birthday greeting is easy to keep at a few seconds, but education about a procedure might be longer. If the content is going to be more than eight to 10 minutes, consider breaking it down into a series of shorter videos.

2. Think like a patient:
   Videos for patients should be geared to patients. Think about common questions patients ask. Make sure the content is in a language and tone that will appeal to patients. Using complex medical terminology probably isn’t the right approach. However, educational videos for existing patients may need a slightly more serious tone than videos for prospective patients that are more about the practice and providers.

3. Show you are the expert:
   Seventy-two percent of patients look for health information online. Demonstrate to them that you are the expert and provide the education you want them to see.

4. Make it shareworthy
   Finally, and most importantly, make any video content you create engaging and easy to share. Videos should be fun and grab people’s attention. A birthday greeting or “meet our staff” video can be as funny as you want. You might tone it down a bit for education on a procedure, but it can still be fun. The added bonus is that the more engaging the video is, the more likely it is to be shared.

   With these best practices in mind, any practice can create videos to help their practice connect with patients.

   You don’t need a lot of fancy recording equipment. Today, a good smartphone or tablet and internet connection are enough to get started.

Josh Weiner, is chief operating officer for Solutionreach. Send your practice management questions to medec@ubm.com.
Succeed at MIPS as a private practice

Ryan Mire, MD, FACP, of Nashville-based multi-specialty practice Heritage Medical Associates, stressed the importance of understanding Medicare’s Quality Payment Program (QPP) in a session geared specifically for private practices.

“QPP is a program we need to understand to get paid,” he said. “The bottom line is that we all want to make more money, but we definitely do not want to lose money. So you want to make sure to at least get the minimum score of 15 to at least keep our current payment rate from CMS. The better you do, the more incentive.”

Mire, who was involved with the QPP at his 140-physician private practice, detailed several best practices for private practices to survive and potentially even thrive under MIPS, including:

- **Become recognized as a patient-centered medical home.** “A lot of the same concepts for PCMH translate into results in MIPS from quality improvement and using an EHR to just clinical improvements,” he said. Under MIPS, such recognition gives practices full credit for the clinical improvement activities category, “and that’s one less pillar (in MIPS) to worry about,” he told Medical Economics.

- **Incorporate HEDIS measures.** Utilizing the Healthcare Effectiveness Data and Information Set (HEDIS) at a practice to measure performance on care standards can go a long way, he said. It can also assist—or translate—in the success of commercial value-based programs, which often take their lead from Medicare. Several HEDIS measures align with MIPS criteria.

- **Utilize available tools.** Getting educated on the QPP is critical, he said. This includes utilizing tools from the ACP, CMS, and other professional organizations that are geared toward helping small practices with finding the best measures for them to report on.

Use EHRs to build trust with patients

With a little planning and forethought, EHRs can actually improve doctor-patient communication and cause both parties to see them as a valuable tool for improving care.

That was the message Wei Wei Lee, MD, MPH, assistant professor of medicine at the University of Chicago’s Pritzker School of Medicine, delivered in her ACP 2018 session.

Lee discussed research she and colleagues undertook a year after the Pritzker School and its clinics adopted EHRs, looking at how use of the computers affected patients’ perceptions of their doctors. They distilled their ideas into the acronym HUMAN LEVEL:
Honor the first minute of the patient encounter: It sets the tone for the rest of the visit, by talking to the patient and not using EHRs or any other form of technology.

Use the “triangle of trust”: Create a triangle configuration in the room that allows the physician and patient to both view the EHR and the physician to address the patient.

Maximize patient interaction: Allow time by encouraging the patient to ask questions if they don’t understand something.

Acquaint yourself with the patient’s chart: Reviewing notes and other pertinent information before entering the exam room.

Nix the screen: When a patient starts discussing a sensitive or emotional topic, turn away from the EHR screen and look only at the patient.

Let the patient look on while entering information into the EHR: Doing so not only helps build trust with the patient but ensures the accuracy of the information because the patient is there to confirm it.

Eye contact: Maintain it as much as possible throughout the visit.

Value the computer: Talk about the benefits of the EHR, and make it a tool for engaging patients by jointly reviewing data such as lab results and specialists’ reports. “If you display negative emotion towards EHR that can leave a lasting impression that isn’t good,” Wei said.

Explain what you’re doing: Be open about everything you’re doing with the EHR in the patient’s presence.

Log off: Signing off of the patient’s chart while the patient is present helps reassure them that their information remains private and won’t be viewed by anyone else.

Recognizing, reacting to social determinants of health

In a recently released paper, the ACP featured nine policy recommendations to address social determinants of health. They include the organization’s support for increased efforts to evaluate and implement public policy interventions and promotion of social determinants of health lessons in medical education.

“We need to teach people how to do this,” said Sarah Candler, MD, MPH, chair-elect of the ACP’s Council of Resident/ Fellow Members. “We need to acknowledge social determinants and know that not everyone has the same opportunities, but also have policies to teach [physicians] how to look for them and policies to address them.”

Candler practices at the Michael E. DeBakey VA Medical Center and talked about the challenges she faces every day with her patients in improving well-being, but also taking social factors into account before, during, and after a visit.

“As a primary care doc, I tell my patients all the time that my job is to keep them as healthy as they want to be for as long as they want to be that way,” she said. “Unfortunately, it’s disappointing to know that sometimes my patients can’t get there because of some of these social determinants of health.”

Candler discussed the “homework” she gives patients and tasks they can perform to keep them healthy between visits, but acknowledged she has some extra learning to do as well.

“It’s my job as a doctor to make sure my patients’ voices are heard when they don’t have those things,” she said. “I think it is my job, as a doctor, to look for those reasons my patients may not be able to have the same opportunities for health.”

ABIM says MOC changes keep it relevant, meaningful

This marks the year the American Board of Internal Medicine rolls out its new “knowledge check-in,” a shorter, lower-stakes exam than the previous 10-year maintenance of certification (MOC) test. The 90-question exam allows internists and nephrologists to take the exam at home, in their office, or at a designated testing site and use UpToDate, an online, evidence-based clinical decision support tool, essentially creating an “open-book” exam.

Marianne Green, MD, board chair-elect for the ABIM, said the organization heard from members that the current 10-year format was “no longer relevant or meaningful,” hence development of this more flexible alternative.

Green said 2018 and 2019 will serve as “no-consequence years” for physicians taking the new test. If they fail the exam, they can take it again in 2020 without losing certification. After that grace period, if a physician fails two subsequent knowledge check-ins, they must take the 10-year exam to maintain board certification.

“What isn’t changing,” Green said, is “that board certification matters to many physicians ... It’s a credential people are proud to hold and it has real performance standards behind it. That should mean something to you and mean something to your patients.”
‘Champions’ to address, relieve physician burnout

As part of its ongoing effort to combat physician burnout, the American College of Physicians is developing a team of “professional satisfaction champions,” whose goal is to improve doctors’ sense of professional satisfaction and personal well-being at the chapter and individual level.

“This [burnout] is a complex problem, and an online tool kit is not going to solve it,” said Cynthia Smith, MD, FACP, vice president for clinical programs at the ACP. “It’s also a human problem, requiring a human solution.”

The first cohort, consisting of 80 champions from ACP national and international chapters, recently completed their training, Smith said. Among their first tasks is “get the word out about the gravity of the problem,” and encourage other physicians to make the case for addressing it at the practice and institutional level.

In addition, champions have been trained in how to measure burnout levels at the individual and group level, identifying doctors at risk, and making evidence-based interventions to head it off and help doctors feel better about themselves and their work, Smith explained.

Overheard at the conference

“[We need to] help physicians realize [medicine] is not about being a good golfer, but a good soccer player.”

—Karen B. DeSalvo, MD, MPH, former HHS acting secretary and national head of health IT, speaking about the need to equip new doctors on a partnership mentality starting in med school

“Google basically any disease and enter ‘and medical marijuana’ and you will often get very convincing YouTube videos…the problem is that many of our patients consult with the internet and may come to you, especially if you are in a cannabis legal state—and even if you are not—and ask you [for medical marijuana].”

—Charles V. Pollack, Jr., MD, FACEP, director of the Center for Medical Cannabis Education & Research on patient education and demand for medical marijuana

“If you have somebody on chronic methadone, don’t waste your time with lubiprostone. It’s just not going to work.”

—Brian E. Lacy, MD, PhD, professor of medicine for the Mayo Clinic in Jacksonville, Fla., on drug options available for opioid-induced constipation

“A possible solution is to have physicians with expertise in clinical medicine and research develop measures using clinically relevant methodology. Performance measures should be fully integrated into care delivery so they can help to address the most pressing performance gaps and direct quality improvement.”

—Jack Ende, MD, MACP, ACP immediate past-president on the group’s call to take a “time out” on federal value-based care initiatives due to physician frustration with current performance measures

“Promoting gender equity and addressing the challenges women in medicine face, including workplace discrimination, work-life balance, and expanding leadership opportunities for female physicians, is a longstanding goal of ACP. Tackling these issues is essential for the internal medicine community to benefit from the full potential of female physicians in the workforce.”

—Susan Thompson Hingle, MD, MACP, chair of the ACP Board of Regents, on the need to continue to eliminate gender inequality in medicine
Opioid abuse has become an ever increasing epidemic in the United States. The use of opioids is on the rise across the entire country, but individuals with Medicare Part D are among some of the most affected. As of 2016, one in three Medicare Part D beneficiaries had received at least one prescription for opioids and one in 10 received prescriptions for regularly scheduled opioids.

Due to this increased health safety concern, public health programs such as CMS and the CDC have launched an extensive investigation to find a solution to this epidemic. CMS has started numerous initiatives to investigate patients and prescribers affected by this epidemic. Through these investigations, they hope to identify problems and create new guidelines for prescribers to follow in an effort to reduce opioid abuse especially in patients on Medicare Part D. The CDC has followed suit with new guidelines that focus on improved patient-physician communication regarding treatment goals and outcomes. The new guidelines state that opioids should only be considered if the risks outweigh the benefits, which is best determined by discussing your patient’s goals of pain relief. If opioids are prescribed, the patient should be started on the lowest dose of immediate release medication and increased as needed from there. The CDC’s new recommendation is to avoid a dose greater than 90 morphine milligram equivalents per day. Along with establishing goals before treatment, the CDC recommends frequent follow up to monitor effectiveness and compliance.

Identify at-risk patients

The first step a prescriber can take to lower opioid abuse is to work to identify at-risk patients. CMS has found that there are two groups of patients at high risk for opioid use disorder. The first patient population is patients that are on high amounts of opioids, defined as an average daily morphine equivalent dose (MED) greater than 240 mg for 12 months. While these patients may have chronic pain conditions requiring high-dose pain medication for control, the high doses put them at increased risk for development of an addiction. The CDC does not recommend opioids be used as first-line treatment for chronic pain disorders. Instead, it recommends non-pharmacological treatments such as osteopathic manipulative treatment or physical therapy or non-opioid pain medications. The other patient population are patients who have received large amounts of opioids, had four or more prescribers, and filled prescriptions at four or more pharmacies—a practice known as doctor shopping. Using traditional methods of identification has allowed these patients to avoid prescribers from noticing patterns of opioid use and abuse.

Understand the CMS Opioid Misuse Strategy

CMS is the national leader in research and guidelines for Medicare and Medicaid. It has taken great interest in this epidemic and has worked to create programs and guidelines to help prescribers reduce opioid over-prescription. The organization has identified four priority areas: Within each of these priority areas, CMS has worked to create programs to achieve its goals of decreasing opioid overprescribing.

1. Implement person-centered and population-based strategies to reduce the risks of opioids.

CMS has worked with quality improvement organizations and action networks to improve the access doctors have to...
There is tremendous scrutiny over prescription of opioid medications for the use of pain management, especially for Medicare Part D participants. Make sure to keep up with the current CDC and CMS guidelines on prescribing opioids along with their recommendations on alternative treatments for chronic pain. By being more conscious about prescribing opioids, physicians can protect their patients and themselves from becoming victims of the opioid epidemic.

3 Expand tools required to diagnose and treat opioid use disorder. Medication-assisted treatment (MAT), a combination of behavioral and medical treatment, has been proven to be the most effective treatment for opioid use disorder. Eighteen months after treatment with MAT, patients were twice more likely to avoid opioids when compared with patients not treated with MAT. CMS is working to improve access to MAT by increasing the locations across the country along with education for prescribers about this effective treatment.

4 Increase use of evidence-based practices for pain management. Just like guidelines for prescribing opioids, CMS is working to increase the distribution of alternative treatments for pain. They are working to implement EHR protocols, trainings, webinars, and education to help prescribers understand all of the treatment options. CMS is also working to increase coverage of these alternative treatments so they will be more accessible to patients.

The CDC has also recently developed an “Opioid Prescribing Guideline” mobile app that serves as a quick reference guide for healthcare professionals to help apply the recommendations of the CDC Guideline for Prescribing Opioids for Chronic Pain in clinical practice. The tool is intended to educate providers about the prescription opioid overdose epidemic and to inform clinical decision-making. The app was released in 2016, and most recently updated in January 2017.

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Janis Coffin, DO, FAAFP, FACMPE, is chair of primary care at the College of Osteopathic Medicine and Kelsey Boyle, OMS III, and Jon Health, OMS III, are medical students at Kansas City University. Send your legal questions to medec@ubm.com.
Physicians have no say in the mergers and consolidations shaping the future of primary care. But plenty is at stake for healthcare clinicians.

The giant players in healthcare—insurers, providers, pharmacies, and pharmacy benefit managers (PBMs)—are scrambling to get bigger and add capabilities in order to compete with each other and with new entrants in the industry, including Amazon and retailers like Walmart.

Some of the mergers could create a new model of primary care, one in which much of the care now provided by physicians in their offices could be done by mid-level providers working in retail settings.

“IT's the wild, wild West. Obviously, it's going to be very disruptive to the primary care environment,” says Theresa Hush, CEO of Roji Health Intelligence, a Chicago-based consulting firm.

Mergers and acquisitions in healthcare are not new, of course. Recent decades have seen independent practices absorbed by multi-group practices which, in turn, join hospital-based healthcare systems, which have merged with other large systems. Those so-called horizontal deals join firms in the same market sector.

Some of the latest mergers are different, however, because they often involve not just healthcare providers, but insurers, retailers and PBMs, which are third-party administrators of prescription drug programs for commercial health insurers. These new transactions are vertical integrations, which blur the traditional lines that once delineated roles and responsibilities in the healthcare sector.

While the companies involved say the mergers will lead to greater efficiencies, lower costs, and better healthcare, the decisions are being made largely by profit-oriented CEOs, not those on the front line of daily patient care. Not surprisingly, many doctors are skeptical of the motives and outcomes.

“I fear that any merger in healthcare is going to be harmful for patients and doctors,” says Marni Jameson Carey, executive director of the Association...
**Trends**  
Healthcare mergers

“My impression is that this is not going to be good for me and my patients. [Retail clinics] are steadily chipping away at the physician-patient relationship.”

—DONALD COLLINS, MD, SOLO INTERNIST, ORLANDO, FLA.

**WHAT TO DO NOW**

While the effect of mergers on primary care is beyond the control of doctors, that doesn’t mean they should be passive, says Kenneth Hertz, FACMPE, principal consultant for the Medical Group Management Association.

The first step he recommends primary care physicians take is to analyze their patients by age, gender, health, family situation, employment, income, and insurance status, particularly if they’re covered by a carrier involved in a merger, such as Aetna.

Knowing that will help forecast how many patients are likely to be affected by a merger or be in a position to seek primary care at a retail clinic, whether by choice or because their insurer pushes them to do so. For example, Hertz says, a family with two working parents might be interested in the longer hours and shorter waiting time at a retail clinic.

Primary care practices can compete with retail clinics by offering better customer service, he says, including shorter wait times, answering messages faster, and emphasizing patient service and satisfaction. In some cases, practices might have to match the competition’s hours, though that might not be affordable for many small practices, he acknowledges.

“The office isn’t open for the convenience of our staff; it’s open for the convenience of our patients. If the extended hours are more convenient for patients, then we need to evaluate that,” he says, noting that a handful of practices have opened their own clinics to compete with retail clinics.

Lastly, he recommends educating patients on the benefits of seeing their own physician rather than a mid-level in a drugstore clinic. “There is a lot primary care physicians have to offer that’s more than the patient can get at a MinuteClinic and they need to make patients aware of that,” he says.

**VERTICAL INTEGRATION**

The deal drawing the most attention is CVS Health’s purchase of Aetna. The $69-billion deal, which has been accepted by shareholders of both companies and is awaiting approval from the Department of Justice, creates a company that is combines a pharmacy, insurer, PBM, and retail health clinic operator.

CVS, which has 1,100 convenient care clinics at its stores, intends to add more and expand their services with the goal of becoming a “community-based health hub” that can improve patients’ health and answer their questions about their health conditions, as well as prescription drugs and health coverage, according to the company.

All of the above sounds like the role of primary care physicians, says Carey. “I think this is a step for insurance companies to get into the business of providing healthcare, which is a business I don’t think they should be in,” she says, adding that insurers are more likely to be concerned with their bottom line than with patients’ health.

Since that deal was announced last December, it’s been reported that Walmart is in talks to buy Humana, a transaction which would create a similar hybrid of retailer/pharmacist and insurer.

**CONCERNS OVER CARE**

Convenient care clinics at CVS and elsewhere have been in existence at least since 2000. Many patients prefer them because of their longer hours, greater accessibility, faster service, and often, lower costs. But...
the services they offer have been limited because care is usually provided by nurses, nurse practitioners, and physician’s assistants, not doctors.

But the combined company will now have a financial incentive and the means to steer Aetna’s 22 million customers to CVS clinics, not only for prescriptions and vaccinations, but for expanded primary care services, such as management of chronic conditions and home monitoring.

That worries Donald Collins, MD, an internist and solo practitioner in Orlando, Fla. He has watched more of his patients go to retail clinics for routine care, such as flu shots and colds. He’s worried that a CVS-Aetna (or Walmart-Humana) merger will result in patients going to clinics for more serious care, to their detriment and his own.

“My impression is that this is not going to be good for me and my patients. [Retail clinics] are steadily chipping away at the physician-patient relationship,” Collins says. “I worry I will lose control of my patients.” He says most patients don’t know that clinics are staffed by mid-level providers and not physicians. “I worry that patients aren’t going to have the same level of care,” he says.

One of the most important services he offers is guiding patients through the healthcare maze with advice and referrals to specialists he knows are good, Collins says, whereas a mid-level in a retail clinic might not be able to do that. He says losing patients to retail clinics also will hurt practice revenue, adding, “There may come a point where I can’t continue to do this.”

Primary care practices are losing patients to the estimated 12,000 retail clinics and urgent care centers. Office visits to primary care doctors declined 18 percent from 2012 to 2016, even as visits to specialists increased, according to the Health Care Cost Institute. According to industry group Convenient Care Association, there are more than 2,400 convenient care (aka retail) clinics in 44 states and Washington D.C., and the number is growing. The clinics have accounted for more than 35 million patient visits.

And a vertically integrated company would have more leverage over primary care physicians even if it doesn’t deliver the care itself, says Chris Kane, MBA, a principal at Progressive Healthcare, a consulting firm in Tennessee. For example, a hybrid insurer/PBM/pharmacist like CVS-Aetna could use its data-mining capabilities to become even more controlling in the drugs and treatments for which it will reimburse providers.

“I think that could be very disheartening to primary care physicians,” Kane says, adding that he expects the new companies to lobby lawmakers to allow mid-level providers to deliver more types of care, which would further cut into primary care practices. And, Kane says, because of their size and integration, the new firms will have even more leverage in negotiating reimbursements with doctors.

**PARTNERING UP**

All the mergers make it harder for primary care doctors to remain independent, says Hush, of Roji Health Intelligence.

A former vice president of UnitedHealthcare and director of the Illinois Medicaid program, Hush says physicians are going to have to change their business models to survive. However, she adds, that doesn’t mean independent practitioners necessarily have to sell their practices or go to work for someone else.

One option is to join an accountable care organization (ACO), but Hush says that doctors should only join one that gives them a voice in management and operations so they can retain control of their practice. Other choices that offer some organizational and financial stability might be a capitated care model and risk-sharing contracts, she says.

Kane, of Progressive Healthcare, says independent primary practitioners also could...
join multi-specialty practices to retain quasi-independence.

Orlando physician Collins says he is considering joining an ACO because of its additional resources and efficiencies, but would rather remain fully independent: “I’m solo by choice. There are a lot of things I complain about but, at the end of the day, I do this because I want to,” he says.

POSSIBLE BENEFITS

Not everyone thinks the mergers will be bad for physicians. A combined CVS-Aetna could be beneficial for patients and physicians alike, says David Blumenthal, MD, president of The Commonwealth Fund, a foundation that works to improve and expand the healthcare system.

“They will not be trying to compete with primary care physicians,” Blumenthal says, adding that a vertically integrated healthcare giant has the potential to work with doctors to make them more efficient.

“I think they can make allies of physicians by offering them services that will help them to manage their caseload,” he says, citing compliance assurance, community management, medication tracking, home care services, and appointment scheduling as tasks that a primary care practice might outsource to such a company.

Progressive Healthcare’s Kane says the new firms might hire more physicians to work in expanded retail clinics to provide primary care, which would offer another career path for doctors.

Payal Bhandari, MD, a primary care doctor in San Francisco, says the primary care model has done a poor job of meeting the needs and preferences of patients and the mergers could fill a gap in care without replacing primary care physicians.

“I think it’s a good thing (for patients),” she says. “Physicians will be OK if they still do their jobs.”

A rundown of the major deals

1. The deal: CVS Health (retail pharmacy and pharmacy benefit manager) buys Aetna
Size: $69 billion
Status: Approved by shareholders. DOJ approval still needed.

2. The deal: Cigna buys Express Scripts (PBM)
Size: $67 billion
Status: Waiting approval

3. The deal: Albertsons buys 2,500 Rite Aid pharmacies
Size: Not disclosed
Status: Will be completed this year.

4. The deal: Optum buys DaVita Medical Group
Size: $4.9 billion
Status: Under review

5. The deal: Amazon, Berkshire Hathaway and JPMorgan Chase to form independent healthcare company for their employees
Size: Unknown
Status: Planning stages

6. Possible deal: Walmart to buy Humana
Size: Unknown
Status: Rumored to be in early talking stages

7. Possible deal: Walgreens to buy AmerisourceBergen (wholesale drug distributor)
Size: About $25 billion
Status: Talks broke off this winter, but could resume
The true cost of switching EHRs

by MARY K. PRATT Contributing author

Physicians have good reasons to change EHRs. They switch systems to one that better meets their needs or integrates more easily with other healthcare practices in their region and hospital system. Sometimes they’re making the move because they want a better user interface or more robust features.

In fact, 62 percent of respondents to the Medical Economics 2017 EHR Report had already switched systems at some point in their careers.

Experts say the payoff for making the switch can be positive, with gains coming from increased efficiencies and productivity gains. But they also warn that the costs of moving from one EHR to another can be significant—and usually much higher than most practices anticipate. From costs for new software and hardware to per-record transfer fees, charges can quickly add up.

Indeed, experts say, the costs of switching EHRs start well before the system is even implemented.

**Research and Negotiation Costs**

Russell Libby, MD, president of Virginia Pediatric Group, saw the bills start as soon as he decided it was time to switch to a new EHR.

At first, the costs were just in his own time as he worked with the other physicians in the practice to get their support for moving forward and as he researched different EHRs to decide which one would work best for his practice.

Then, as the project progressed, Libby involved others from his staff, asking them to review and test EHRs that he identified as contenders. They had to commit more time to review contracts and plan for the switchover project once the EHR was selected, too.

“That time is inestimable,” says Libby, also co-founder of American Pediatric Consultants Inc. and a board member of the Physicians Foundation. “You shut down the practice for an afternoon to see how you operate, compare it to how the system operates, and you may do this for two or three or four EHRs. And you need your whole staff sitting in the room and working with a representative from the vendor.”

Some practices could incur even higher costs, experts say, as many also travel to other practices to see prospective EHRs in action, a move that’s recommended but can mean hours away from seeing patients plus travel expenses.

**The EHR Software Contract**

There are many fees to watch for in EHR contracts, experts say.

HIGHLIGHTS

- Set aside an additional 20 percent of the total implementation budget for unanticipated expenses or underestimated costs when switching EHRs.
- Vendors generally advise practices on hardware and networking requirements, and can sometimes even offer deals on those items.
Switching EHRs

“There are maintenance fees, software subscription fees, support fees. And you might have other fees, like signing up for a database that’s required to run the system or a fee for a coding system,” says Lydon Neumann, vice president at Impact Advisors, a healthcare information technology consulting firm based in Naperville, Ill.

EHR contracts also specify whether and by how much those fees can increase each year, a point well worth watching because typical annual increases of 5 percent or so can add up quickly over the life of a contract, says Kathy Downing, director of practice excellence at the American Health Information Management Association in Chicago.

Moreover, EHRs now bundle functions that were previously in other software, meaning a practice could be paying for capabilities such as scheduling, billing or secure messaging in its new EHR even though the practice may already own those capabilities in other applications, Neumann says.

Although buying all the functions through a single EHR vendor helps ensure those functions work together, physicians should still examine and compare costs and certainly shouldn’t pay for the same functions twice. Experts recommend a cost analysis to know whether taking the bundled features with the new EHR is better than keeping the existing functions with other vendors.

HARDWARE AND OTHER TECHNOLOGY COSTS

Software upgrades can require upgrades in hardware, too, Neumann says. Older printers, monitors, tablets and PCs might not work well with a new EHR, while older servers and networking equipment might not support the higher-intensity computing requirements of some modern applications.

Some practices that implement new EHRs, particularly if they’re moving from a system that ran on office-based servers to a cloud-based version, may also find that they don’t have the internet bandwidth to support the new software—thereby adding additional dollars to the total cost of implementation.

Vendors generally advise practices on hardware and networking requirements, and can sometimes even offer deals on those items, Downing says. “They’re not huge costs compared to other parts of the implementation, but it’s something to understand upfront,” she adds.

Practices also should anticipate the costs of integrating their new EHR with other systems, such as coding and insurance verification applications. These interface fees vary depending on what other systems need to interface with the new EHR and the complexity of the practice’s overall IT environment. For example, a typical office might face costs for integrating its new EHR with a secure messaging application (if not part of the new system) as well as potentially additional integration costs for tying the new EHR in with more specialized equipment, such as the software on an X-ray machine.

The cost and complexity of this work is often lower when the new EHR vendor has experience building interfaces to other applications from specific vendors, Neumann says. Given that, a practice might consider switching some of its other systems to products made by those vendors. That may be a smart move if the contracts for those other systems are nearing their end; however, it’s probably not cheaper or easier to do if that’s not the case or if the practice prefers its existing ancillary systems for any variety of possible reasons.

“A lot of times it takes some custom interfaces, and you might have to pay vendors on both sides [of the project] to make sure it works. And it’s worth having the conversation on whether it’s going to be an ongoing
cost and what it’s going to cost to maintain them,” Downing explains.

CONSULTANTS AND OTHER OUTSIDE EXPERTISE

Some practices hire consultants to help right from the start with the assessment of a new EHR. Libby says he did, noting that it cost him about $2,500 just for this early-stage advice.

For many practices, that’s just the start of the fees they’ll pay to the consultants they’ll hire to help with the EHR switch.

Of course, not all practices want or need multiple consultants, and they may actually find having too many involved can complicate the implementation, Downing says.

Libby, for instance, says he only used a consultant to help with the area where he felt he needed the most help: negotiating the contract. On the other hand, many physician practices, particularly larger ones with more complicated IT systems, use consultants throughout the entire process, from choosing the new EHR to getting the most benefits from it, experts say.

Downing says practices, particularly smaller ones without complicated IT needs, may find that the consulting services that usually come as part of the new EHR contract are adequate and more affordable.

Experts say physicians must decide whether they will need consultants to help them switch to a new EHR and, if so, what consulting services they will need and whether a single consultant or a single consulting firm can handle all of their needs which could range from customization and configuration requirements to staff training and software testing.

Some physician groups also hire project managers to help coordinate all the work, timeline, and personnel involved to ensure that deadlines are met and the implementation stays on track. “All that can get expensive very fast,” says Peter Winkelstein, MD, MS, MBA, executive director of the University at Buffalo Institute for Healthcare Informatics.

Practices frequently have consultants on site the day the new EHR goes live, and even during the first few weeks to get physicians and staff used to the new system and to help with any unexpected glitches.

“You need to provide that support at the point of go-live,” Stephanie Newkirchen, principal in life sciences and health care practice for Deloitte Consulting, says. While the cost can be unpredictable, because practices don’t always know how fast their physicians and staff will learn the new systems, she says practices commonly underfund this line item.

“The cost of that change management is always underestimated,” she warns.

DATA TRANSFER COSTS

Another frequently underestimated cost of switching EHRs is the price tag that comes with moving data out of the old application, experts say. Downing says she has seen costs run into the tens of thousands of dollars for physician groups.

This process may involve fees to both the

Optimization efforts

A year into using his new EHR, Russell Libby, MD, president of Virginia Pediatric Group, decided to send three EHR “super users”—two doctors and one administrator—to a conference sponsored by the EHR vendor so they could learn how to better utilize all the features and functions of the new system.

This advanced training costed about $3,000 per person in travel and conference fees. Libby says this training had additional costs in terms of lost productivity, as they each were away from the office for three days. “I’ve got to spend it, but I’m expecting a return on that. It’s an investment you have to make,” Libby says, noting that he wants to use his new EHR for more advanced projects, such as identifying patients with certain conditions so he can send them tailored messages— for example, identifying patients with asthma so he can send them care reminders ahead of allergy season.

Practices that get the biggest returns on their EHR investments are those who continue to invest in training and optimizing the system, says Taylor Davis, MS-STAT, vice president of innovation at KLAS Research in Orem, Utah. They tweak configurations and incorporate more features and functions into their workflows to make the EHR work for them, rather than the other way around.

Davis cites the case of one physician, who says she uses her EHR’s search functions to find recent tests and uses her filters to highlight relevant information before she walks into the exam room to see a patient, something she says allows her to ask better questions and conduct a more efficient examination. She says she’s configured the EHR in ways that make her documentation easier yet more meaningful as well.

“She’s a power user and it pays off in a big way,” he adds.

Davis says ongoing investments in training and optimizing the practice’s use of the new EHR “is ensuring that your super expensive resources—the physicians—are at full utilization.”
Switching EHRs

“We usually recommend cutting the patient load down by 50 percent in those first few weeks because there’s a real productivity hit there.”

—PETER WINKELSTEIN, MD, MBA, DIRECTOR, UNIVERSITY AT BUFFALO INSTITUTE FOR HEALTHCARE INFORMATICS

FOUR CONSIDERATIONS BEFORE SWITCHING

Determine customization needs.
Many practices have unique ways of handling certain tasks, so they often tweak, or customize, software to meet those distinctive workflows. Decide what customizations you want and contract for those software upgrades before switching over to the new system, so the customized workflows are ready as soon as you go live with your new EHR.

Plan for data transfer.
Transferring data from the old into the new system is a time-consuming and potentially costly endeavor, and it’s nearly impossible to transfer every piece of data. Determine what patient data you need and then work with your new vendor and your tech support to establish a timeline for transferring information and figuring out how the transferred data will appear in the new system.

Determine how to maintain access to old records.
You may need that information at some future point; at the very least you need to maintain patient records for a period of time as set by state laws.

Adjust your schedule.
Although many vendors offer pre-implementation training, scale back on appointments or plan for more work after clinic to accommodate the additional time it will take to learn the new system. Expect your productivity to go down for the first three months to six months after going live with the system.

LOST PRODUCTIVITY
Productivity will almost certainly suffer when switching EHRs, and experts say that the dip in productivity could last months.

“You might have to pay for [your previous EHR] system to stay online just to meet your record retention requirements. That’s one bucket of cost that people just don’t think about and it can surprise them,” Downing says.

Neumann says he advises a 10 percent to 20 percent reduction in scheduled patient visits during at least...

PREVIOUS EHR VENDOR AS WELL AS THE NEW ONE.
Costs vary depending on how contracts are structured. Experts say many existing EHR contracts between vendors and physicians don’t directly address how data will be transferred when the contract expires nor how much it will cost, leaving physicians to negotiate when they’re trying to switch. (That’s why experts advise physicians to address data-transfer fees when they’re negotiating initial contracts with vendors.)

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“The costs there are really human [resources] costs. The time and effort within a workplace to prepare and convert and then to work in a new routine with the EHR is never, never made up by future visits or payments.”

— RUSSELL LIBBY, MD, PRESIDENT, VIRGINIA PEDIATRIC GROUP

The first few weeks following the switch to accommodate the demands of learning the new system, creating workflows within the system, and tweaking interfaces to personal and office needs, although some physicians and staff members will learn the new system faster than others and will be able to return to full schedules more quickly.

Other experts warn that it’s difficult for an office to accurately gauge exactly how long it could take the practice to be back to full capacity.

“It could take at least a month and up to six months before you’re up to full productivity,” Winkelstein, who is also chief medical informatics officer of UBMD Physicians’ Group and chief medical informatics officer of healthcare provider Kaleida Health, says. “We usually recommend cutting the patient load down by 50 percent in those first few weeks because there’s a real productivity hit there.”

UNDERESTIMATED AND UNANTICIPATED EXPENSES

Like any project, switching EHRs can result in unanticipated costs no matter how well a practice thought through an implementation plan. Missed deadlines can increase consulting costs or result in longer downtimes. Integrating the new EHR with other systems could be more challenging than expected. Productivity could dip more or for longer than anticipated.

Despite all his research, Libby says he encountered some unexpected costs for messaging patients shortly after he implemented his new EHR. “I didn't realize [in advance] there was going to be that cost per message. There might be costs not there in the beginning but they’re going to show up. That’s something you have to be aware of,” he says, noting that his experience underscores the need to thoroughly review an EHR’s features and how fees for those are structured.

Neumann advises setting aside an additional 20 percent of the total implementation budget for unanticipated expenses or underestimated costs. “And once you’re into the implementation, that 20 percent should not be erased,” he says. “Think of it as a checkbook that you can draw on as needed, and if it’s not needed, it’s a bonus.”

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‘Internet of Things’ poses new cybersecurity challenges to medical practices

Like a virus that slips past the body’s immune system, ransomware infected the entire network of a large medical practice in the Mid-Atlantic as hackers froze desktops, servers, and laptops used by more than 100 staff members. And these cybercriminals gained entry from the one device specifically set up to protect the healthcare facility from thieves: the security camera.

Instead of exploiting human errors through a phishing scam, hackers instead broke into the computer system via the software that ran the security camera. Because the medical practice had contracted with a third-party security vendor, the camera’s software sat outside the firewall installed to protect the computer network. Using a password cracker, a cybercriminal infiltrated the software, logged in as the IT administrator, and then encrypted everything in the network to spread the ransomware.

Fortunately, the practice was able to get its system restored—but the costly process of rebuilding servers and adding backups took the better part of a week before the network was fully restored.

Unfortunately, security cameras are only one of a countless array of devices and applications that make up the growing digital environment known as the Internet of Things (IoT)—an environment most consumers access through the disembodied voices of Siri or Alexa which connect and communicate data for everything from smart refrigerators to fitness wearables.

Not only is the IoT market expected to grow enormously—up to 20.4 billion devices by 2020 according to Juniper Research—the cybersecurity threats in this new environment are poised to mushroom as well.

Dangerous diagnostics
IoT devices like smart alarms or wireless music systems can leave any business vulnerable to cyber-attacks, but the wealth of private information on patients makes the healthcare sector a particularly inviting target. Many hospitals and medical practices, for instance, have diagnostic equipment like ultrasounds, mammograms, and MRI machines that are not part of their normal network security—or else they operate on outmoded software.

That means any device that is not kept within the protective security perimeter provided by anti-viral measures and firewalls can become an entry point for cyber thieves.

Typically, healthcare practitioners share and exchange diagnostic images from ultrasounds or mammograms through a Proxy Auto-Configuration (PAC) file. But the servers and software used to distribute these PAC files from one location to another within a medical practice or through the cloud may not be updated, nor do they always configure with security best practices.

Three steps to better protection
If medical professionals install firewalls and anti-viral software but neglect to secure the IoT devices that surround their practices, it’s as though they’ve locked their doors but left the windows open.

Besides engaging in ongoing employee education about cyber-threats, practitioners can take these three steps to improve data security in the emerging IoT environment:

- Create a Virtual Private Network (VPN) and use two-factor authentication (2FA);
- Install an Account Lockout Protocol and develop tough password controls; and
- Conduct a rigorous Security Risk Assessment (SRA)

Creating a Virtual Private Network (VPN) provides an encrypted, private connection over the top of a public, less secure network that can be used for remote access and other online tasks. In the case of the hacked medical practice, the security camera was outside the firewall of the protected network, instead of being inside the safety of a VPN. Using two-factor identification—like the temporary code sent to a cell phone for making online payments—adds another layer of protection to the VPN.
Account Lockout Protocols prevent a hacker from getting into a system after a certain number of tries. That tool stops a “brute force” attack by cyber thieves who use password crackers to keep trying an infinite variety of passwords until they break the code. Developing strong passwords creates another line of defense. If the medical practice had installed account lockout technology it could have prevented the hacker from breaking into the active directory, even if the security camera software itself was breached.

A Security Risk Assessment (SRA) is a powerful weapon against cyberattacks because it requires a thorough inventory of every location where data is stored, as well as any point where it is vulnerable. Before the explosion in IoT, that assessment would cover items like mobile phones and laptops along with desktop equipment; but now it also extends to a whole gamut of devices ranging from energy monitors to remote printers. While all the new gadgets in the IoT must be checked for potential security vulnerabilities, it’s also crucial to deal with the host of legacy equipment still in operation. For example, because of cost considerations or compatibility issues, some medical facilities continue to depend on MRIs that run on Windows XP. As noted previously, when any device operates on outdated software, it creates the risk of a data breach, especially when security patches have not been updated.

IoT promises a world of convenience and connectivity in healthcare – but that promise will only be fulfilled if practitioners recognize that security is the most important thing.

What is a security risk analysis?

A security risk analysis involves analyzing vulnerabilities and threats to your system to safeguard electronic protected health information (ePHI). It means reviewing your policies, practices, and systems and correcting any issues that may make ePHI vulnerable.

- Review existing security of protected health information
- Identify threats and vulnerabilities
- Assess risks for likelihood and impact
- Mitigate security risks
- Monitor results

Myths debunked about security risk analyses

<table>
<thead>
<tr>
<th>MYTH</th>
<th>FACT</th>
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<tbody>
<tr>
<td>The security risk analysis is optional for small providers.</td>
<td>The analysis is required for all providers.</td>
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<tr>
<td>Installing a certified EHR fulfills the security risk analysis component.</td>
<td>Security requirements address all ePHI, not just info in your EHR.</td>
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<tr>
<td>I only need to do a risk analysis once.</td>
<td>To comply with HIPAA, you must continue to review, modify, and update your security protections.</td>
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Art Gross is president and CEO of HIPAA Secure Now!, which provides security services to medical practices. Send your technology questions to medec@ubm.com.
The opioid dilemma
doses of opioids for months or years—and patients who’ve been prescribed opioids more recently and are still on relatively low doses. One of the goals of the CDC guideline and subsequent laws and regulations, he says, is to ensure that patients in the latter group don’t become part of the high-dose group.

“But we also have to recognize there are no easy answers for dealing with that high-dose legacy group,” he adds. “You can’t just make the problem go away by saying we won’t pay for that kind of [high-dose] prescribing anymore, because that throws patients into a state of withdrawal.”

Like Tape, Schwartzstein believes that getting patients off opioids, or just lowering their dosages, is a difficult process that has to be tailored to each patient’s needs. “My primary goal is to manage chronic pain so that people can be as functional as possible, so I don’t take opioid pills away from people just for the sake of taking them away. It’s all based on an individual assessment between myself and the patient,” he says.

Wisconsin, where Schwartzstein practices, has no limitations on the quantity of opioids a physician can prescribe, but it does require prescribers to take two hours of continuing medical education on the topic, and to consult the state’s PDMP if they write a prescription for more than three days’ worth of the medications.

Even so, Schwartzstein says, he has changed his approach to opioids over the last few years as their danger has become

Embracing action—and health IT—to fight opioid addiction

One physician discusses how greater collaboration and better communication could show promise in addressing the opioid crisis in Alaska.  

By Anne Zink, MD, FACEP

Alaska’s healthcare system serves a population of 740,000 spread across 663,000 square miles. Given the relatively “small” number of patients cared for within this vast backdrop, it’s easy to believe our state healthcare leaders are giving patients the personalized treatment they need to live their best lives.

But as the opioid crisis sunk its teeth into rural states like ours between 2009 and 2015, we began to see how our good intentions were failing patients. In particular, by prioritizing metrics like patient satisfaction—which CMS’ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey linked to pain until 2016—we were unintentionally enabling addicts.

As our doctors started to see evidence of the opioid crisis escalating (an uptick in patients demanding IV pain-killers, more violence toward clinicians, etc.), we knew we needed to make serious changes to our entire system.

One of biggest motivators for me, personally, was a conversation between physicians and two sober, recovering opioid addicts at a hospital meeting. I’ll never forget when one of the men told us, “Each one of you has given me opiates at some point because your satisfaction scores and getting me out of the emergency department were more important than my life.”

That blew my mind. But facts don’t lie. Many of us have an easier time abiding by a patient’s request for an IV Dilaudid than having a real conversation about what’s driving the patient’s pain. Compounding the problem, every major hospital is owned by a different organization with its own economic drivers and reasons for making decisions, and its own EHR. We’d need to put aside differences to move forward.

A collaborative approach

In 2016, physicians started working with state legislators to draft evidence-based,
more apparent. For patients experiencing acute pain, he now generally prescribes a three- to seven-day supply, whereas before he would prescribe for up to 14 days.

For patients with chronic pain, Schwartzstein first tries to address it with non-pharmaceutical solutions—exercise and physical therapy—and/or non-opioid medications. “If I do start prescribing opioids, it’s only after a careful discussion about the benefits and risks, either for the patient or others who might potentially access them,” he says. He also requires patients to sign a contract under which they agree to get prescriptions only from him, to get the prescriptions filled at a designated pharmacy, and undergo periodic urine screenings.

GROWING ‘OPIOID PHOBIA’

For Dan Glatt, MD, an internist in Burlingame, Calif., specializing in pain and addiction medicine, obstacles to prescribing opioids have come not from any new laws or regulations, but from payers.

He cites the case of two patients who’ve been stable on their medications for several years, but whose insurance (which they get through their spouses who both work for the same employer) recently began limiting its opioid coverage to 90 MME per day, far less than the patients had been using. Now, Glatt says, the patients are having to pay out-of-pocket for their pain medications.

“It puts unnecessary stress on the patients and thereby on their spouses who are clinical prescribing guidelines. It didn’t happen overnight—one area we discussed a lot is how many opiates should be written for a post-acute injury. But it happened, and now we have a document that is easy to read, print out, and post, which includes the logos for all major Alaska hospitals. This makes conversations with patients much easier because we can say, “We are all trying to help you, and to help I need to follow these guidelines.”

These guidelines state, for example, that a single medical provider should prescribe all opioids to treat a patient’s chronic pain, and that best practice is for this provider to be the patient’s primary care provider or pain management specialist.

The second thing we did is implement a software-based network solution that pulls together essential patient medical data, including frequency of ED visits in our facility and outside hospitals, and pushes this data into a one-page document ready at the point of care. The data is consolidated, so I can quickly see if a patient has been frequenting other EDs or has had issues with opioids or other drugs in the past. Then, I can take more informed actions, such as talking to them about alternative treatments and support services.

We’re excited for what’s to come. The network system, which is provided by care coordination platform provider Collective Medical, helped care teams in Washington state reduce narcotic prescriptions from the ED by 24 percent. And for our hospital, the impact of the network and guidelines has been transformational. We’ve seen a 61 percent reduction in opioid scripts written between 2015 and 2017 and a 47 percent reduction in opioids given in the ED. The system has changed the conversation between ED doctors and patients and is totally focused on their health — not patient satisfaction scores.

There is a difference between enabling patients and truly helping them. While we still have a long way to go, I’m thrilled we’re making progress with the latter.

Anne Zink, MD, FACEP is the emergency medicine medical director for Mat-Su Regional Medical Center in Palmer, Alaska, and immediate past president for the Alaska chapter of the American College of Emergency Physicians. She also sits on the clinical advisory board for Collective Medical.

“Docs who were prescribing now are afraid to because they don’t want to show up on a list or think the DEA is going to show up at their door.”

— DAN GLATT, MD, INTERNIST, BURLINGAME, CALIF.
the actual employees and who are afraid to complain about the situation because they don’t want to lose their jobs,” he says.

In addition, Glatt notes that a growing number of physicians in his region now refer patients to him out of what he calls “opioid phobia.”

“Docs who were prescribing now are afraid to because they don’t want to show up on a list or think the DEA is going to show up at their door,” he says. “They either want a blessing from me because they know I treat addiction and pain, or they just don’t want to take care of these patients anymore, even though the patient’s doing fine and has been stable on their meds for years.”

Like many specialists in addiction medicine, Glatt believes the solution to the opioid crisis lies in devoting more resources to helping addicts and keeping outside interference to a minimum. “It gets more and more frustrating to practice clinical [addiction] medicine when nonclinicians are telling us how to prescribe,” he says. As for what would help, he cites the need for more detox services and for medically assisted treatments, such as opiate blockade and replacement therapies.

**BURDENS ON PRACTICE**

Georgia, where internist Sandra Fryhofer, MD, MACP practices, recently enacted several laws aimed at curbing opioid abuse.

Beginning July 1, physicians who are licensed to prescribe the medications must register with the state’s PDMP, check the database when they first prescribe a controlled substance for a patient and every 90 days thereafter (and document that they’ve done so), inform patients about the addictive properties of opioids before prescribing them, and take at least three hours of CME on safe opioid prescribing before receiving or renewing their medical license.

The law allows practices to assign up to two staff members to check the PDMP, thereby relieving physicians of some of the time required. Even so, “It’s going to be a burden because everyone is already busy in a small primary care office,” she says, adding that the process would be easier if the PDMP could be integrated into electronic health records. On the other hand, “It’s not too much to ask if we can save a life,” she adds.

The Medical Association of Georgia also lobbied unsuccessfully for a law that would have required commercial insurers in the state to provide coverage for opioid addiction treatments and opioid alternative treatments for patients. “All these things are ways that we could keep from having to give patients pain pills,” she says.

Fryhofer adds that the law’s failure is emblematic of a larger problem: Too few lawmakers, regulators and payers involved in trying to solve the opioid crisis truly understand its complexities or the resources the effort requires. “But they do understand we have a deadly epidemic on our hands that continues to claim more and more lives and something has to be done to stop it,” she says. “And they know that a lot of the cycle of opioid prescribing begins with clinicians, so they want to make us part of the solution.”
Physicians operate their practice like a business. That means the way the government calculates patient access is dead wrong.

There are three reasons. First, physicians must meet payroll, pay rent and utilities, secure insurance, and repay student loans. So a physician may “choose” to not accept a new patient. Actually, it’s a patient’s insurance that they are choosing to accept or decline.

Second, most practices have multiple physicians. In Mississippi, we found the average primary care practice was composed of three physicians. As such, they share office space, staff, and business practices. As a business decision, they may choose not to accept new Medicare patients in their practice. Having health insurances does not automatically equal access to healthcare. We called all the primary care practices in the state of Mississippi. Patients with some form of Blue Cross & Blue Shield insurance, some 95 percent of practices, were willing to set a new patient appointment. If you had Medicare, the acceptance rate statewide was closer to 75 percent. But only about half of the practices would consider accepting a patient with Medicaid (a needs-based insurance). Having health insurance did not guarantee access to primary care. It depended on the type of health insurance.

Third, the federal government treats each individual physician as a stand-alone point of access to the healthcare system. Three physicians equals three access points, despite the fact that all three have agreed on what kinds of health insurance to accept from new patients. This calculation, called the Health Professional Shortage Area (HPSA), is an important score. When your county’s HPSA score is high (which is bad) a number of programs designed to address the physician shortage problem kick in. There are multiple programs that offer incentives for physicians and other healthcare professionals to come and practice medicine in those underserved areas.

The problem is HPSA scores drastically overstate access. Take a typical rural county in Mississippi. There might be nine primary care physicians in the county. The HPSA score would be based on nine individual, independent, access points. The more physicians there are, the lower the HPSA score. But, those nine physicians are grouped in three practices. Nothing has changed except that we are now recognizing the reality of the marketplace.

The HPSA scores need to take into account the reality of access, how it differs across payer types and how there are fewer access points than records would suggest.

The first step is to have every physician report on their annual license renewal form if they are in a practice and who they practice with. The second action is for physicians to report on their annual licensure form what percentage of their patients have different kinds of insurance. From that, we can calculate the acceptance rates for different insurance type by county and adjust HPSA scores accordingly. For example, a county with low acceptance of Medicaid would earn a high HPSA score and multiple programs would kick in to encourage physicians to move to and serve that area.

We can address the imbalance between the demand for healthcare and the supply of healthcare. We need to start by more accurately measuring that imbalance. And it is as easy as changing the physician license renewal form. The results will be better allocation of healthcare to underserved places.

Ronald E. Cossman, PhD, is a research professor and health geographer at the Social Science Research Center at the Mississippi State University. He is director of the Mississippi Center for Health Workforce.
Who are your role models?

Maria Young Chandler, MD, MBA
Business of Medicine / Pediatrics
Irvine, Calif.

“My father, who is a child psychiatrist and the most patient person I know.”

George G. Ellis, Jr., MD
Internal Medicine
Boardman, Ohio

“My family doctor growing up.”

Antonio Gamboa, MD, MBA
Internal Medicine / Hospice and Palliative Care
Austin, Texas

“Steve Jobs, Elon Musk, Warren Buffet, and [University of Texas-El Paso President] Diana Natalicio.”

Jeffrey M. Kagan, MD
Internal Medicine / Hospice
Newington, Conn.

“[Fellow physician] John C. Tapp, MD.”

Melissa E. Lucarelli MD, FAAFP
Family Medicine
Randolph, Wis.

“Mrs. Kobida (my 8th grade math teacher), Marie Curie, and my mom.”

Joseph E. Scherger, MD
Family Medicine
La Quinta, Calif.

“[Neurologist] David Perlmutter, MD.”

Salvatore Volpe, MD
Pediatrics/Internal Medicine / Pediatrics
Staten Island, N.Y.

“My parents.”

The board members that contribute expertise and analysis to help shape content of Medical Economics.
“If I do start prescribing opioids, its only after a careful discussion about the benefits and risks.”

ALAN SCHWARTZSTEIN, MD, PRIMARY CARE PHYSICIAN, OREGON, WISC.

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“I think this is a step for insurance companies to get into the business of providing healthcare.”

MARNI JAMESON CAREY, EXECUTIVE DIRECTOR, THE ASSOCIATION OF INDEPENDENT DOCTORS

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How much experts advise reducing patient load after switching EHR systems

50%

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“50% of experts advise reducing patient load after switching EHR systems.”

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